P-IRO Inc.

An Independent Review Organization

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Notice of Independent Review Decision

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Neurosurgery

Description of the service or services in dispute:

1 bilateral lumbar facet rhizotomy at L3-L4 and L4-L5 under fluoroscopy and sedation

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☐ Upheld (Agree)
- ☑ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Information Provided to the IRO for Review:

Patient Clinical History (Summary)

The patient is a female who was injured on xx/xx/xx and was followed for chronic low back pain stemming from L5-S1 posterior lumbar interbody fusion in 1997. The patient previously underwent lumbar facet rhizotomy procedures at L3-4 and L4-5 on 01/11/13 with repeat procedures on 01/28/14. The patient was being followed who reported at least 60% improvement from prior rhizotomy procedures. The clinical evaluation on 02/18/14 reported at least 50-60% improvement since last rhizotomy procedure on 01/28/14. The most recent clinical evaluation on 01/16/15 noted the patient had recurrence of facet related pain which required Robaxin and tramadol. With rhizotomy the patient had normal activities of daily living; however, this was recently impacted due to pain. Physical examination noted intact strength in the lower extremities with positive straight leg raise signs at 80 degrees producing low back pain only. The patient had strong facet signs with tenderness to palpation in the lumbar paraspinal musculature. Range of motion was restricted on extension to 10 degrees. Due to prior response to facet rhizotomy procedures repeat rhizotomy at L3-4 and L4-5 was ordered. Letter dated 02/05/15 noted 70% relief from last rhizotomy procedures in 01/14. Pain score was reduced from 7-8 intensity to 3-4 following procedure. The patient reported severe pain during procedures which required local sedation. Patient indicated that after rhizotomy procedure she was able to utilize less medication. The proposed lumbar facet rhizotomy at L3-4 and L4-5 was denied on 01/27/15 as there was lack of clinical documentation supporting successful rhizotomy at L3-4 or L4-5 and lack of indication for sedation. The requests were again denied on 02/10/15 and 02/17/15 as there was no clinical documentation of decrease in medication use and pain relief for at least 12 weeks.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The clinical documentation submitted for review addresses the concerns of the prior reviewer of efficacy of prior radiofrequency rhizotomy procedures at L3-4 and L4-5. Per the last rhizotomy procedures at L3-4 and L4-5 resulted in 70% pain relief for more than 12 weeks with a reduction in pain medications. indicated the patient had severe pain during the procedures which required sedation. Per guidelines there should be at least 50% relief following lumbar rhizotomy procedures for 12 weeks to support repeat procedure. Guidelines do not recommend more than three procedures performed in a year. As the patient had more than 12 weeks of pain relief at 70% with reduction in medication the guideline recommendations regarding repeat radiofrequency ablation procedures would be met. The request is limited to no more than two joint levels. The clinical documentation also established the need for sedation due to severe pain experienced during prior procedures. Therefore it is the opinion of this reviewer that medical necessity for the request is established and prior denials are overturned.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
  Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)